Gordon (S. C.)

THE MECHANICAL TREATMENT OF STERILITY, WITH A REPORT OF CASES.

A PAPER

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Maine Medical Association,

JUNE 11, 1878.

BY S. C. GORDON, M. D., OF PORTLAND,

LECTURER ON DISEASES OF WOMEN IN THE PORTLAND SCHOOL FOR MEDICAL INSTRUCTION; ONE OF THE ATTENDING SURGEONS AT MAINE GENERAL HOSPITAL, ETC.

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MECHANICAL TREATMENT OF STERILITY.

By "mechanical," I mean treatment without the use of what has generally been denominated surgical procedure.

The various operations of "posterior incision of the cervix uteri," "amputation of the cervix," "division of the internal os," &c., &c, that were so fashionable a few years since, and were taught and practiced by the leading men of the profession and still adhered to by some, have been found by the more sober-thinking men to be attended with so much danger, many times proving fatal, frequently followed by inflammation, and, in a majority of cases, proving unsuccessful in their results, that they have wisely abandoned them and given their time and attention to the discovery of means to accomplish the same end with less risk, and, if the process is slower and the modes of procedure less brilliant in character, they are better satisfied than when they operated more heroically and encountered dangers so commonly incident to the more heroic methods. A more critical analysis of the causes that produce sterility has led to the belief that no one condition is of *paramount* importance, which, if relieved by some surgical procedure, fertility will, as a rule, follow. The general treatment of uterine disease has often been followed by a cure of sterility, but in what the particular lesion consisted, or just what was done to remove it, has too often been overlooked. This is only natural with physicians who are in general practice and are thus being driven from one thing to another. The men who have given more special care to these cases, and whose principal work is in the department of gynecology,

like EMMETT, THOMAS, PEASLEE, GRAILEY HEWITT and BARNES, have been continually making new discoveries in lesions, and inventing new methods for treating them. Especially are these men, and men like them, carefully avoiding all modes of treatment that, in the hands of younger and less experienced men, are liable to produce disastrous if not fatal results. Therefore, we find that the operation for "posterior section of the cervix" has been well nigh abandoned, as a rule; the risk of pelvic inflammation is too great and the result too unsatisfactory. While an occasional case, that has resisted all other methods and has shown that manipulations about the generative organs are well borne, is treated by this operation, the general sentiment of the profession is opposed to it and to all similar surgical procedure. The tendency among thinking men is to a less severe system of management of *all* uterine lesions. The doctrine of inflammation of the uterus, with the natural sequelæ of inflammation, ulceration, suppuration, &c., has comparatively few advocates at the present day.

The more rational doctrine of "chronic passive congestion," as taught so long, so forcibly and logically by PEASLEE, finds favor with the thinking, rational men of the profession, who, accepting this or similar views, are fast discarding the bold measures, both medical and surgical, that have been productive of so much harm and so little good. THOMAS, who, as an author and didactic teacher, stands foremost in the ranks of this class, says (and I trust I may be pardoned for the liberal quotation): "The excessive surgical tendency of many of the leading gynecologists of our day is a matter to be deplored by all who wish well to gynecology. Many conditions, which time and patient medical treatment would readily cure, are met boldly, and without sufficient consideration, by operations more or less formidable. Every practitioner must often have seen cases in which pelvic peritonitis or cellulitis has arisen from an incision of the neck of the uterus, or some similar procedure, in which the patient is for months confined to bed, and in which he is forced to doubt the necessity for the surgical resource which has been productive of the evil. No one who reads these pages will suspect me of a want of appreciation of the operations to which I have alluded, nor of timidity in employing them. I regard them

as great advances in gynecology, and in practice commonly resort to them. It is not to their use, but to their abuse, that I am objecting. The last remark applies with almost equal force to the exclusive reliance which by many seems placed upon the local treatment in the cure of uterine disorders. One who frequently sees cases of uterine disease in consultation, will meet with many in which he is called upon to urge cessation of all local treatment as the first step in the proper management of the case." Words like these, coming from a man who has always been a most careful investigator, and has had the moral courage to say boldly when he believed he had been led into error, mean more than the theories of men who learn nothing from their mistakes, or at least admit nothing. My own experience within the past few years, though comparatively limited, has fully impressed me with the truth of the views so clearly expressed by Dr. THOMAS, and my practice has been based upon them. Especially is this true in the treatment of sterility. I am very free to admit that the heroic means have not answered my expectations, even when the utmost care has been used; either harm has been done, or, in a majority of cases, no good has resulted therefrom. I have made the various operations so much in vogue ten or fifteen years ago, and, as a rule, have been disappointed. During the past five years, I have been content to "go slow"—treat only what I was *absolutely sure* existed, and treat it in the most careful manner. If by this course as much good has not been accomplished, certainly not as much harm has come. The following cases I select as illustrative of this principle of treatment. They were treated from the first with the one end in view, viz: to cure sterility. The results were not accidents, as in many other cases I might give.

CASE I. Mrs. G., aged about thirty-three years; married seven years; had never been pregnant; had been treated for a large portion of her married life for some uterine trouble, just what, I could not learn, as she never knew. She was a tall, well-developed woman, and never suffered from any severe symptoms; occasionally had attacks of "nervous dyspepsia," complicated with general neuralgic pains in head and other parts of body. Her treatment had been of quite a heroic character, judging from her account of

the suffering experienced at the different times. Dysmenorrhœa, which had been her most important symptom, was not relieved, and the menstrual periods were prolonged more and more at each recurring flow. I saw her first in November or December, and found retroversion in second degree; no flexion; os small, though not extremely so; the general condition of uterus, congested; no adhesions or evidence of pre-existing parametritis. I began by carefully anteverting the uterus, holding it in position by the sound for a time, and afterwards applying the glycerine pack. This was followed two or three times a week for a month, when I introduced a THOMAS retroflexion pessary and allowed it to remain one week, then removing it for a day or two, in the *interim* using the glycerine. After removing it two or three times at longer intervals, I replaced it and let it remain three months. This was the principal part of the treatment, except once or twice a week I dilated the os by means of an urethral sound, applying the glycerine at each examination. Being absent in the following August, she removed the pessary, and became pregnant almost immediately, passing her regular period in September. In the following June, she was safely delivered. Practically, the principal part of the treatment consisted in restoring the uterus to its normal position, thus relieving the congestion and restoring its lost function.

CASE II. Mrs. S., aged thirty-eight; married twenty years; had borne two children, the younger sixteen years old. The older one about to be married, the mother was desirous of having another child, and as no means had been used to prevent pregnancy since last birth, she applied for treatment of her sterile condition. I found retroversion in the third degree, and a consequent hyperplasia to a great extent—function of menstruation almost entirely suspended. There being no adhesions, I anteverted and applied a THOMAS retroflexion pessary, advised using freely large injections of hot water, removed the pessary occasionally, alternating with local astringents. In a few months I found absorption going on and a return of the menstrual flow. Within fifteen months from commencement of treatment she became pregnant and passed through her gestation safely, wearing her pessary until the end of the fourth month. In fact, she became pregnant while wearing

the pessary. So great a degree of flexion and version existed in this case, that, in making a digital examination, the fundus of the uterus was felt just within the vagina.

Case III. Mrs. L., aged about thirty; married seven years; never pregnant; desirous of children; consequently no means used to prevent. Previous to her marriage, I had treated her for a very serious dysmenorrhœa. She had retroversion, with *firm adhesions*, rendering the uterus practically immovable, together with a sharp anteflexion. Uterus abnormally small, measuring not more than two inches upon the inside; os and cervix very small; her dysmenorrhœa was but partially relieved when she married. I saw but little of her for several years after marriage—occasionally treated her when the dysmenorrhœa was so severe as to be unbearable. I felt that nothing but pregnancy could break up the adhesions that were binding the uterus down. The case seemed about as unpromising as one could be. Three years ago she came to me, saying that she was willing to submit to anything that promised the least hope of relief from her present sufferings. I could give her but little encouragement, but told her if she would patiently persist in treatment, I hoped to be able to sufficiently straighten the uterine canal that she might become pregnant. I commenced by passing the sound every few days, straightening the uterus and holding it in position (as far as possible) for several minutes each time, decreasing the curve of the sound at each operation, until I could introduce the straight, stiff French sound. I made a point of doing this, particularly, just before and after each menstrual period. Occasionally, I applied a laminaria tent, leaving it for twelve hours. By thus putting the adhesions upon the stretch each time, I was able, after a time, to apply a small Hodge pessary, which she could retain for a few days. After each operation I always packed with glycerine to relieve any congestion that might exist or be produced. This course, patiently and persistently followed by patient and myself for a year and a half, was finally rewarded by the best of all results (the one hoped for), pregnancy. Last July she was delivered of a healthy boy, after a most tedious instrumental labor.

The last case, Mrs. T., I saw last March; married three years;

herself and husband apparently healthy, robust people. She complained of no uncomfortable symptoms whatever—not even the slightest dysmenorrhœa. She came to know if anything could be done to cure her sterility, as both she and her husband were anxious for children. On examination, I found what Dr. BARNES considers one of the most prominent causes of sterility, viz: a contracted os. I gave her only the usual encouragement, that if she would have patience and perseverance, I hoped we might accomplish the result desired. There was no displacement, no enlargement, in fact, no one thing that could be called abnormal, except the contracted os. I made a very small incision on each side, to the depth of two or three lines, kept it open by cauterizing the edges, and about every three days passing a sound or dilator. In less than two months she became pregnant, and now suffers more from sympathetic disturbances than ever before since her marriage, and, like many another before her, is almost sorry she did not remain in her old condition.

These four cases represent different conditions of uterine disease which produce sterility. Formerly, I should have believed it almost impossible to treat successfully the case of Mrs. L. (where anteflexion existed to such a degree) without the posterior incision of the cervix. I am convinced that many like cases may, under the same general management, be equally successfully treated. In the use of pessaries, I would caution the inexperienced against allowing patients to wear them unless they watch them very carefully. No pessary should ever be left that does not support the uterus easily, and, at the same time, can be readily moved about in the vagina. No fixed, firm pressure can be tolerated for any length of time. As much care should be observed in fitting them as the most skillful shoemaker takes in fitting the feet of his customers. With these precautions, pessaries are invaluable and absolutely indispensable; indeed, a certain class of cases are not cured, or even benefited, without them. Injudiciously used, the cases not only are not benefited, but they are made very much worse. No one form of pessary can be advised or used in all cases, and yet I find myself using the various modifications of THOMAS'S retroflexion

and anteversion. For many cases, I have used, and found valuable, a pessary invented by Dr. Higbee, of Springfield, Mass.

But, whatever the name or style may be, each case must be fitted, and no pessary should ever be applied that cannot be removed by the patient herself, while full instructions should always be given for doing it. Especially is this true of anteversion pessaries. Much more harm is done by pressure between the uterus and bladder, than in Douglass' cul-de-sac. Therefore anteversion pessaries become more dangerous than retroversion, and have formerly been made so that the patient was unable to remove them. Any pessary should be removed after a few days, and astringent treatment employed for a time, until the parts become accustomed to the foreign body. In dilating, I have found slippery elm bark tents valuable, being well borne. Peaslee's dilators seem to answer the purpose better than any other I have seen. In the use of all these means, the utmost care should be taken, lest inflammation ensue. The object being to rectify displacements and deformities, as a precedent to the removal of passive congestion, time is an important element, therefore no great risks need be taken. Patience and perseverance will ultimately be rewarded.

DISCUSSION.

Dr. Tewksbury said that in cases of flexion of the uterus, causing contraction of the canal, he was in the habit of incising the cervix and dividing any contraction at the internal os, thus straightening the canal. He had obtained the best results from this plan of treatment. A large proportion of the cases of sterility were relieved, as well as the dysmenorrhœa which so generally accompanies this condition.

Dr. Gordon said his experience with this operation had not been as good as Dr. Tewksbury's. He had had trouble follow it, and for the last four or five years he had worked to avoid it. He preferred to straighten the uterus by other means, whenever it was possible.

Dr. Brickett related a case of a woman who had been barren for twelve years on account of a retroversion of the uterus. The uterus was replaced and supported by a pessary. She became pregnant, but after delivery the retroversion returned as before. Two years later, the same treatment was repeated, with the same result, and after the second confinement the displacement of the uterus was as bad as ever.

Dr. Dana said there seemed to be two classes of cases, very widely separated. In the cases spoken of by Dr. Tewksbury, there was great flexion and stricture, associated with great irritability of the nervous system. Then we know that there are many cases in which, by reducing the congestion and gradually correcting the displacement of the uterus, the sterility might be overcome. He would like to ask the experience of members as to their success in treating cases of anteversion as compared with retroversion. In his experience, the former were much the harder to cure.

Dr. Gordon said that had been his experience till the last two years. But since Dr. Thomas had introduced his anteversion pessary, he had had more satisfaction in treating cases of anteversion than retroversion.

Dr. Brickett and Dr. Tewksbury both said they had not had such good results with this or any other anteversion pessary.